STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155751	A. BUILDING 00 B. WING	07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	200 MEADOW LAKE DR MOORESVILLE, IN 46158

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 23, 24, 25, 26, 27, 30 and 31, 2012. Facility number: 004831 Provider number: 155751 AIM number: 200809750 Survey team: Marcy Smith RN TC Patti Allen BSW Leia Alley RN [July 23, 24, 25, 26, 27, and 31, 2012] Dinah Jones RN [July 23, 24, 25, 26 and 27, 2012] Census bed type: SNF/NF: 106 SNF: 20 Residential: 62 Total: 188 Census payor type: Medicare: 22 Medicaid: 83 Other: 83 Total: 188 Residential sample: 7 These deficiencies also reflect state	F0000	The creation of submission of this Plan of Correction does not consitute an admission by this provider of any conclusions set forth in the statement of deficiences or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in Lieu of a Post Survey Revisit on or after August 21, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review 8/03/12 by Suzanne Williams, RN			

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F0203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State			

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	long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.			
	Based on record review and interview, the facility failed to provide notification of transfer or discharge to 2 of 3 residents reviewed for receiving notification of transfer or discharge. (Residents #3 and #11) Findings include: 1. The record of Resident #3 was reviewed on 7/30/12 at 9:00 a.m. Resident #3 was admitted to the facility for therapy on 12/27/11. She was discharged from the facility on 2/27/12 to an assisted living environment with recommendations to continue her therapy to help her acclimate to her new surroundings. She was not given a Notice of Transfer or Discharge informing her of the reason for her discharge or her	F0203	It is the practice of this facility to provide residents and/or responsible parties transfer or discharge notifications and reason prior to move in writing and in a language and manner they undertand; record the reasons in the resident's clinical record; and include in the notice the items described in paaragraphy (a)(6) of this section.1. Resident #3 and #11 no longer reside at facility.2. Residents discharging from the facility have the potential to be affected by the same practice. *The Social Services Director re-inserviced social workers and licensed nursing staff on transfer/discharge notification requirements to include the reasons for the move and appeal rights by August 13, 2012. Also instructed them on placing a copy of notification in medical record. *The Interdisciplinary team will review transfers and	08/21/2012

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	appeal rights. During an interview with the Social Service Director on 7/30/12 at 11:35 a.m. she indicated she was not able to find whether the notice had been given to the resident. She indicated at this time she did not think it was necessary to give this Notice to Resident #3 because the resident was requesting and agreeable to the discharge. 2. The record of Resident #11 was reviewed on 7/30/12 at 9:30 a.m. She was admitted to the facility on 2/8/12 and discharged from the facility to the hospital on 4/9/12. No documentation was found in the resident's record to indicate she or her husband was given a Notice of Transfer or Discharge informing them of the reason for her discharge or her appeal rights. During an interview with the Social Service Director on 7/30/12 at 11:25 a.m. she indicated she did not know if this Notice was given to the resident. She thought it probably was because "they're supposed to give it." Review of an admission packet "Resident Handbook, Resident Rights & Advanced Directives," dated		discharges to ensure proper tranfer/discharge notification were provided to the residents and/or responsible parties during AM Meeting.3. * Discharge/Transfer packets and checklist are preassembled and available at the nursing stations for distribution to residents prior to transfer/discharge. *Interdisciplinary Team (IDT) will review transfer/discharges at morning meeting to ensure all required notification were provided to the resident and/or responsible party at the time of discharge. Any residents lacking documented proof of transfer/discharge will be contacted by phone and provided a verbal notification. Additionally, the written copy will be mailed to them. Staff failing to provide proper notification at time of transfer/discharge will receive additional training and/or disciplinary action up to and including termination.4. The Social Services Director is responsible to monitor transfer/discharge compliance.* The SSD and/or designee will utilize the Transfer/Discharge CQI tool weekly x4, bimonthly x1 month and at least six months thereafter. The SSD will report results of audits to QAA for further action and or followup as indicated. Re-education and/or disciplinary action will be used for non-compliance.	

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	1/2011, received from the Administrator on 7/23/12 at 12:00 p.m., given to each resident at the time of their admission to the facility, indicated "(4) Notice before transfer. Before an inter facility transfer or discharge occurs, the facility must...(i) Notify the resident of the transfer or discharge and the reasons for the move in writing...(ii) The health facility must place a copy of the notice in the resident's clinical record...(7)...the written notice...must include the following: (i) The reason for transfer or discharge...(iv) A statement...that reads, 'You have the right to appeal the health facility's decision to transfer you....'" 3.1-12(a)(6)			

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F0247 SS=A	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a resident was notified when she was going to get a new roommate for 1 of 1 residents reviewed for being notified of roommate changes. (Resident #74) Findings include: The record of Resident #74 was reviewed on 7/26/12 at 10:00 a.m. Diagnoses for Resident #74 included, but were not limited to, depression, chronic pain, and diabetes. During an interview with Resident #74 on 7/23/12 at 2:05 p.m. she indicated she had had "about 14" different roommates in the last year. She indicated sometimes the facility told her when she was getting a new roommate, but "usually they just pop in." On 7/30/12 at 11:30 a.m. the Social Services Director provided a list of Resident #74's roommates since July, 2011. The list indicated she had had	F0247	It is the policy of this facility to provide residents notice before room changes or new roommate placement.1. Social Services met with resident #74 and ensured that there are no adjustment issues or concerns. Resident #74 encouraged to notify social worker with any concerns. Resident #74 will be informed of roommate change prior to change if one occurs.2. Residents receiving new roommate are at risk of this same practice. Social Services Director reinserviced social workers, admissions and licensed nursing staff on requirement to provide resident's notice of room or roommate change prior to the event by August 13, 2012.3. * Upon approval of new admission Social Services and/or Nursing will inform resident and/or responsible party that a new room-mate will be admitted and document in medical record.* Upon an Emergency Admission and/or unanticipated room move licensed nursing staff will inform resident and document in medical record.*Change in room and/or roommate notification will be monitored daily Monday - Friday by IDT (and Saturday and Sunday by nurse	08/21/2012

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	8 roommates during the year. The Social Services director indicated she could only find change of roommate notification given to Resident #74 on two of the roommate changes. She indicated at this time she was aware residents were supposed to be notified when they were getting a new roommate. Review of a "Resident Handbook, Resident Rights & Advanced Directives," dated 1/2011, received from the Administrator on 7/23/12,given to each resident at the time of their admission to the facility, indicated "(ii) The facility must also promptly notify the resident...when there is (A) a change in room or rommmate assignment;..." 3.1-3(v)(2)		manager) to ensure all appropriate notifications were provided to residents and documented in medical records.* Any residents lacking documented proof of room/roommate change will be assessed by Social Services for adjustment issues or concerns.* Staff failing to provide proper notication at time of room/roommate change will receive additional training and/or disciplinary action up to and including termination. 4. The Social Services Director is reponsible to monitor room/room-mate change notification to residents.* SSD and/or designee to utilize Room move/new roommate audit tool weekly x4, bimonthly x1 month, and for at least six months thereafter. The SSD will report results of audit to QAA for further action and or followup as indicated if non-compliance is noted. Education and/or disciplinary action will be used for non-compliance.	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure they followed their plan of care for assessing a resident after he fell for 1 of 3 residents reviewed for following the facility fall plan of care in a sample of 6 who met the criteria for falls. (Resident #144) Findings include: The record of Resident #144 was reviewed on 7/27/12 at 1:00 p.m. Diagnoses for Resident #144 included, but were not limited to diabetes, orthostatic hypotension, dementia and diabetic neuropathy. A review of a fall circumstance report/investigation form "Fall Events" indicated after a resident falls assessments included, but were not limited to, whether they had a history of orthostatic hypotension (a drop in blood pressure upon change of position) and diabetes. The form indicated if the resident was a diabetic, an accucheck (measurement	F0282	It is the policy and practice of this facility to provide services by qualified persons in accordance with each resdient's written plan of care.1. Resident #144 has been reassessed for Fall Risk and their careplan has been updated accordingly. 2. Residents at risk for falls are at risk from this practice. The licensed nursing staff have completed a new fall risk assessment for all residents. Careplans have been updated as indicated.3. Director of Nursing Services reinserviced licensed nursing staff on accurate completion of the fall risk assessment by August 13, 2012.* IDT will review fall risk assessments daily (nursing manager Saturday and Sunday). Fall risk assessments will be reviewed to ensure information accurately reflects residents plan of care. Any licensed nursing staff inaccurately completing a Fall Risk Assessment will receive further re-education and/or disciplinary action up to and including termination.4. The Director of Nursing Services is responsible to monitor completion of Fall Risk assessments.*Fall CQI tool will	08/21/2012

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	of blood sugar) was to be done. Review of fall investigations for Resident #144, completed by Licensed Practical Nurse (LPN) #1, dated 7/9/12 at 8:45 a.m., 7/12/12 at 9:57 a.m. and 7/13/12 at 10:45 a.m. all indicated the resident did not have a history of orthostatic hypotension or diabetes. No accuchecks were done at the time of these falls. During an interview with the Director of Nursing on 7/30/12 at 1:00 p.m. she indicated the resident was not appropriately assessed after the above falls and accuchecks should have been done. A physician's order, dated 7/16/12, after the falls indicated "Hx [history] of multiple falls. When he falls 1. check accucheck..." A facility policy, received from the Director of Nursing on 7/27/12 at 2:00 p.m., dated 3/10, titled "Fall Management Program, indicated "...4. A fall circumstance report will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions..."		be utilized by DNS and/or designee weekly x4, bimonthly x 1month, and monthly for at least six months. The DNS will report results of reviews to the QAA monthly for further action and/or followup as indicated. Noncompliance will result in re-education and/or disciplinary action.	

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	3.1-35(g)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to prepare, distribute and serve food under sanitary conditions and equipment used to prepare food was maintained in a sanitary condition during 2 of 2 kitchen observations. This had the potential to affect 126 of 126 residents who received meals from the kitchen. Findings Include: 1. During the dietary walk through on 7/23/12 at 10:50 a.m., with the Dietary Manager the following was observed: Dietary Staff #1 was observed to have facial hair uncovered, as he prepared food, handled the dishes and assisted with meal service. Three of four different size skillets in use had Teflon interior that was 1/3 gone. The only remaining Teflon was on the sides, and small areas on the	F0371	It is the policy and practice of this facility to prepare and store food under sanitary conditions.1. Employee #1 has been re-inserviced on appropriate hairnet/beard guard use per facility policy. Skillets with missing teflon were removed from use immediately and new ones purchased.2. To assist other residents affected by this practice all cookware was reviewed to ensure in good condition and staff were re-trained on proper hairnet requirements.3. *Dietary staff re-inserviced on Policy and Procedure concerning personal Hygiene including hairnet use for hair/beards/moustaches and on Policy and Procedure concerning safety and equipment maintenance per Executive Director/desginee by August 13, 2012.*Cooks and dietary staff to report any equipment concerns/damage to Dietary Manager/RD daily. Damaged equipment will be removed from service logged by dietary staff.*Dietary Manager/RD to monitor dietary employee hygiene and hairnet/beard guard usage and condition of equipment to	08/21/2012

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	bottom. In an interview with Dietary Manager on 7-23-12 at 11:15 a.m., she indicated the skillets were used to prepare food for the residents, as she took them out of service. 2. On 7-27-12 at 10:35 a.m. during lunch preparation and service the following was observed: Dietary Staff #1 was observed to have facial hair uncovered, as he prepared lunch trays, handled dishes and assisted with meal service. In an interview with the Dietary Manager on 7-31-12 at 3:00 p.m., she indicated it was the facility policy that the dietary staff with facial hair (mustaches and beards) to be covered when in the kitchen. Facial hair should be covered during handling, preparing, and serving food. Dietary Manager indicated that the above mentioned concerns had the potential to affect 126 of 126 residents who received meals from the kitchen. 3.1-21(i)(3)		ensure it's in good repair. Employees will receive additional training and/or disciplinary action up to and including termination if failing to comply with requirements. * Cooks responsible to ensure dietary staff on each shift is compliant with Hairnet /beard guard use. Employees that fail to follow Hairnet/beard guard requirement will receive additional training and/or disiciplinary action up to and including termination.4. RD is reponsible to ensure compliance with Sanitary and Hygiene Policy requirements.* RD and/or DSM will utlizeHair/Beard Covering and Equipment CQI audit tool weekly x4, bimonthly x 1 month, and monthly thereafter for at least six months to ensure personal hygiene and dietary equipment is compliant with policy.* RD responsible to report audit results to QAA monthly for further recommendations and/or actions as indicated. Non-compliance will result in additional training and/or disciplinary action.	

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F0504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview, the facility failed to ensure physician's orders were obtained prior to labs being drawn for 1 of 10 residents reviewed for having orders for labs. (Resident #125). Findings include: The record of Resident #125 was reviewed on 7/25/12 at 2:00 p.m. Diagnoses for Resident #125 included, but were not limited to, anemia, stage 3 chronic kidney disease and a history of multiple myeloma. A recapitulated physician's order for July, 2012, with an original date of 5/26/12, indicated Resident #125 was to have a CBC (complete blood count) drawn every week. A physician's order dated 6/13/12 indicated the resident was to have a CBC drawn monthly. Another physician's order dated 6/15/12 further indicated "1. DC [discontinue] weekly CBC 2. Monthly CBC."	F0504	It is the policy and practice of this facility to provide laboratory services only when ordered by the attending physician.1. Resident #125 no longer resides at facility. 2. Residents receiving lab services could be affected by this practice. Lab orders were reviewed for residents receiving lab services to ensure MD order compliance. The lab was informed of audit outcome to ensure lab draws are in compliance with MD orders.3. The Director of Nursing Services re-inserviced licensed nursing staff on the Labortory Services process to include, obtaining MD order, alerting Lab, and monitoring Lab draws to ensure compliance with MD orders by August 13, 2012.* Charge nurse will compare pre-lab draw sheet to MD orders and resident medical record to ensure physician orders are being followed.* Charge nurses will place lab results in binder for unit manager review. Unit Managers will review all lab results daily (Monday - Friday) and charge nurse on the weekend to ensure compliance with MD orders.4. The Director of Nursing Services is responsible to ensure compliance with the Lab services	08/21/2012

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	155751	A. BUILDING 00 B. WING	07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	200 MEADOW LAKE DR MOORESVILLE, IN 46158

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A review of lab results for Resident #125 indicated a CBC was drawn on 6/13, 6/18, 6/25, 7/2, 7/9, 7/11, 7/16 and 7/23, 2012. Further information was requested from the Director of Nursing on 7/26/12 at 10:00 a.m. regarding the continuing weekly CBC's being drawn after 6/13/12. On this date at 4:00 p.m. she indicated the 6/13/12 order from weekly to monthly for the CBC draws did not get changed on the recapitulated July, 2012 physician's orders and the laboratory missed the order change. She indicated the facility did not notice the CBC's were still being drawn weekly. 3.1-49(f)(1)		process.* DNS and/or designee will utilize Lab CQI tool to audit process weekly x4, bimonthly x 1 month, and monthly for at least six months thereafter. DNS will report lab audit results to QAA monthly for for at least six months. Further action and/or followup as indicated.	